

MDR Tracking Number: M5-04-1585-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 2-2-04.

The IRO reviewed chiropractic manipulation and physical medicine treatments 2-5-03 to 10-27-03.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. Consequently, the requestor is not owed a refund of the paid IRO fee.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division. On 5-13-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

On 10-19-04, the requestor submitted a withdrawal on the additional issues.

The above Decision is hereby issued this 22nd day of October 2004.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

April 20, 2004
Amended April 26, 2004

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #: M5-04-1585-01(2)
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to

___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the care rendered to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Doctor of Chiropractic. The reviewer is on the TWCC Approved Doctor List (ADL). The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

The patient suffered a gradual onset of pain in the right upper extremity from repetitive trauma on her job and was treated by Dr. V for the injury, beginning in ___. She was treated with very extensive passive and active modalities after being diagnosed with shoulder and wrist strains, carpal tunnel syndrome and a cervical somatic dysfunction. Daily care was instituted for about 3 weeks and was reduced to 3 times a week thereafter. The patient was removed from work at that point in time. Documentation from the provider indicates that EMG was negative on this case. MRI of the cervical spine was fairly normal, with only a 1 mm bulge at the level of C5/6 and this did not impinge upon the neural structures. Office notes were received from the requestor. The respondent sent a peer review from Dr. T along with EOB's and HCFA forms that were sent from the provider's office.

DISPUTED SERVICES

The carrier has denied the medical necessity of chiropractic manipulation and physical medicine treatments from February 5th to October 27th in 2003.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

The reviewer finds no documentation, in spite of extensive paperwork sent by the requestor that would justify this type of treatment. The diagnostic testing provided was generally negative and the office notes were not reasonably indicative of a results-

oriented approach to the case. The provider in question continued to administer extremely extensive passive care along with active care that seemed to not be getting any form of results. Prior to the disputed period, the treating doctor had administered similar treatment that lacked significant results. As a result, the care rendered has not been demonstrated to have resulted in a standard of care that would be described as reasonable and necessary.

____ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ____ has made no determinations regarding benefits available under the injured employee's policy

As an officer of ____, I certify that there is no known conflict between the reviewer, ____ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

____ is forwarding this finding by US Postal Service to the TWCC.

Sincerely,